

The Impact of Solution-Focused Brief Therapy with At-Risk Junior High School Students

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Recently, the use of solution-focused brief therapy (SFBT) has received considerable attention in school settings. However, limited empirical evidence supports the utility and effectiveness of SFBT with at-risk students. Therefore, the purpose of this research was to evaluate the impact of SFBT with a group of at-risk students in a junior high school. A total of 26 students participated in eight group sessions of SFBT in a junior high school located in central Ohio. Compared with pretreatment assessments, students participating in SFBT had higher scores on behavioral and social scales at posttreatment and at six-week follow-up. This finding was also uncovered on the external assessments completed by parents and teachers. Implications for school social workers and the treatment of at-risk populations in school settings are discussed.

KEY WORDS: *at-risk students; outcome research; school underachievement; solution-focused brief therapy*

Over the past two decades, the term “at risk” has received considerable attention. Many authors have gone to great lengths to define and articulate the complexities associated with the term (Carnegie Council on Adolescent Development, 1989; Dryfoos, 1990, 1998; Kazdin, 1993; Resnick & Burt, 1996). Along these same lines, research has developed understanding of the major risk and protective factors associated with at-risk populations (Bryson, 1997; Collingwood, 1997; Kominski, Jamieson, & Martinez, 2001).

For some, *at risk* refers to the increased likelihood over base rates that a youth would engage in a particular behavior that results in psychological, cognitive, and social impairment (Dryfoos, 1990; Kazdin, 1993; Resnick & Burt, 1996). Others, however, point to the exposure of environmental issues such as homelessness, poverty, dangerous neighborhoods, and family dysfunction that place youths at-risk (Dryfoos, 1998; Hechinger, 1992; Thompson & Kelly-Vance, 2001). With such considerations studies cite the alarming number of youths engaged in activities (for example, substance abuse, sexual activity, delinquency, dropping out of school) or put in situations (for example, homelessness or socially deprived rural and urban areas) that place them at risk (Dryfoos, 1998; Hechinger).

Along with the complexities associated with being at risk, the term also describes children and adolescents facing an uncertain future in K–12 educational settings. Routinely, studies cite the history of absenteeism, tardiness, below average school achievement, low expectations, external locus of control, and behavioral problems associated with at-risk youths (Dryfoos, 1990; Nunn & Parish, 1992). More important, these studies point to the increased likelihood of school failure and the probability of these youths dropping out of school (Dryfoos, 1998). As a result, the necessity of uncovering interventions and support services that enhance the overall school achievement of at-risk youths in K–12 education becomes paramount.

K–12 professionals such as school social workers seek to provide the greatest optimal level of growth for at-risk youths by focusing on the progression, development, and evaluation of interventions. Solution-focused brief therapy (SFBT) has received interest in addressing at-risk youths in school settings. With emphasis on collaborative goal formulation that focuses on client strengths, researchers and practitioners have applied or proposed the use of SFBT as a practical and sensible alternative in school settings (Corcoran, 1998; Dielman & Franklin, 1998; Franklin, Biever, Moore, Clemons,

& Scamardo, 2001; Littrell, Malia, & Vanderwood, 1995; Murphy, 1997; Selekman, 1993; Thompson & Littrell, 1998; Watkins & Kurtz, 2001).

Despite promising results, a limited number of outcome studies have been conducted testing SFBT with at-risk youths in school settings (See Gingerich & Eisengart, 2000). Thus, there is a critical need to assess SFBT as a possible treatment alternative. I conducted a study to assess the impact and effectiveness of SFBT with junior high school students in central Ohio who were identified as being at risk of behavioral, social, and academic failure.

APPLICATION OF SFBT IN SCHOOL SETTINGS

Over the past decade SFBT has been applied or suggested with youths coping with emotional and behavioral disorders (Franklin et al., 2001; Thompson & Littrell, 1998), youths coping with ADHD (Dielman & Franklin, 1998), addressing the overrepresentation of African American youths in special education (Watkins & Kurtz, 2001), and parents seeking interventions for their "difficult" youths (Selekman, 1993). SFBT has been proposed as a progressive model that focuses on strengths and solutions rather than problems and deficits (Corcoran, 1998; Dielman & Franklin; Franklin et al., 2001; Kurtz, 1997; Murphy, 1997; Murphy & Duncan, 1997; Selekman, 1993).

In using SFBT in school settings, practitioners focus on changing future behavior by constructing behavioral tasks that lead to rapid solutions for youths (Franklin et al., 2001). Such solutions in behavior are achieved by shifting the youth's focus from one of despair and deficiency to one of hope and potential. To enhance and shift behaviors, multiple techniques in the SFBT model have been discussed to help facilitate practice with at-risk youths (Corcoran, 1998; Franklin, Corcoran, Nowicki, & Streeter, 1998; Kral, 1995; Kurtz, 1997; Selekman, 1993). The shift from deficiency to potential is achieved by displaying a nonjudgmental demeanor that allows for open dialogue; by using solution-oriented language that emphasizes exceptions and potential solutions; by using future-oriented questions such as the miracle question, which allows the at-risk youth to envision a reality and life without the problem; by using scaling questions, which allow the at-risk youth to pay attention to goal development; and by using direct and indirect com-

pliments that focus on the at-risk youth's strengths and resources (Corcoran, 1998).

Given the techniques associated with SFBT, at-risk youths may begin to co-construct with school social workers a reality that focuses on their future success in school. SFBT empowers the school social worker and at-risk youth with the ability to pursue relative and common goals necessary for success. At-risk youths then cultivate a sense of control and responsibility that enables them to navigate their own behavioral, social, and educational experience.

METHOD

The study was designed to answer the following questions: Will SFBT enhance the social skills of at-risk youths as measured by the Social Skills Rating System (SSRS) (Gresham & Elliott, 1990)? Will SFBT enhance the classroom behavior of at-risk youths, as measured by the Behavioral and Emotional Rating Scale (BERS) (Epstein & Sharma, 1998)? Will SFBT enhance the completion of homework by at-risk youths, as measured by the Homework Problem Checklist (HPC) (Anesko, Schollock, Ramirez, & Levine, 1987)?

Recruitment of Participants

The student population for this study was between ages 11 and 14. Participants were selected from the current seventh and eighth grade roster from the participating central Ohio junior high school. Potential participants for the study were defined as "any student in the seventh or eighth grade identified as being at risk of academic problems based on below average academic performance and/or chronic and/or low attendance from the previous academic year and who was not receiving or currently under the provisions of an individual education plan (IEP)."

The assistant principal and two school counselors compiled a list of 90 students deemed at risk of behavioral, social, and academic failure. Outlines and letters that explained the study in detail were mailed to the parents of potential participants. Each letter provided an overview of SFBT, the length of the study, the intervention focus, and a request for their participation. A parental consent form was also mailed to the parents. Consent letters had to be signed and returned before the onset of treatment. A total of 28 students were available to participate in the study. In keeping with university

requirements, Ohio State University's Human Subjects Committee and Internal Review Board (IRB) approved all study procedures for the requirement of human participants.

Providing SFBT Group Treatment

The research study began in mid-January 2002 and concluded during mid-March 2002. Two MSW II interns (one man and one woman), the school social worker at the junior high school, and I facilitated the delivery of SFBT to four groups. Initial placement of the participants in the SFBT groups was based on class schedule, the grade of the student, and the likelihood that SFBT would not interfere with the student's academic classes. Eight seventh-grade students were placed in group A, conducted by the school social worker; eight seventh-grade students were placed in group B, conducted by the male MSW II intern; six eighth-grade students were placed in group C, conducted by the female MSW II intern; and six eighth-grade students were placed in group D, conducted by me. Each group met on Mondays except for one week in January because of the Dr. Martin Luther King Jr. holiday. During that week, each group met on Wednesday during their usual time.

The rationale for using a SFBT group modality was based on several reasons. First, it was important that group members recognize that they were not alone in having issues pertaining to behavioral, social, and academic failure. It was equally important to provide group members with an opportunity to share their thoughts and feelings about school success. It was then anticipated that group members would have the experience of getting support from group facilitators and group members while also recognizing that they are valuable and worthwhile people despite their challenges. Such opportunities and experiences allow group members to form a connection with others and to increase their consciousness and commitment to action (Kurland & Salmon, 1992). The content covered in each group is discussed in the following section.

- **Session 1: Introductions.** Obtained informed consent for participation. Discussed group expectations. Discussed the goals of the group (that is, to increase academic competence, classroom conduct, homework completion, and attendance levels).

- **Session 2: In-Session Assignment.** Students were asked "What academic/school goals do you have this semester?" and "What do you hope to achieve by participating in this group for the next eight weeks?" Used the miracle question.
- **Session 3. Use of the Scaling Question.** Students were asked "On a scale from 1 to 10, with 1 being your academic/school goals not achieved and 10, your academic/school goals completely achieved, where would you rate yourself as a student today?" Homework assignment for next week: "Where would you like to be on the scale at the end of the semester, and provide the group with ways you will accomplish this increase" (goal and future oriented).
- **Session 4. Review of Session 3 Homework Assignment.** Held group discussion on "signs of success" in achieving academic/school goals. Homework assignment for next week: First, "If I asked Mr./Ms. _____, your _____ teacher how he/she had witnessed these signs of success in your academic/school goals, what do you think he/she would say?" (that is, the relationship question). Second, "please write down your signs of success in which you came closer to reaching your end-of-the-semester score on the 1 to 10 scale."
- **Session 5: Review of Session 4 Homework Assignment.** Used the solution-focused brief therapy technique EARS (that is, elicit, amplify, reinforce, and start over). Used the exception-finding question to amplify and reinforce present and future change.
- **Session 6: Revisit the Scaling Question.** Gave homework assignment: A letter from the "older, wiser, self" (Dolan, 1995). "Imagine that you have grown to be a healthy, wise old man/women and you are looking back on this period of your life. What would this older wiser man/women suggest to you, which helped you get to where you are now in your academic/school goal(s)?"
- **Session 7: Review of Session 6 Homework Assignment.** Discussed how the "new" self had emerged: Used EARS. Homework assignment: "A letter from the future."

- **Session 8: Review of Session 7 Homework Assignment.** Discussed setbacks as being normal. Passed out certificates of success.

Ensuring Treatment Integrity

To ensure treatment integrity the two MSW II interns and I were trained in the application of SFBT at an eight-week course during summer 2001. My academic adviser, who has extensive practice experience with the SFBT model, conducted the SFBT training. Training consisted of lecture material, videotapes, and role playing using the SFBT technique. The school social worker, who had taken classes at Ohio State University on the application of SFBT, was also provided with videotapes and reading material before the onset of the study.

Detailed steps were conducted to ensure the treatment of SFBT. I developed the protocol used in the study to ensure a group focus on the outcome measures of social, behavioral, and homework assignments. SFBT group facilitators met one hour before each treatment session to discuss the focus of the groups as outlined by the SFBT protocol. Last, participants had to complete at least five of the eight sessions to be included in the data analyses.

Data Source and Instrumentation

Selection of the instruments was made on the following criteria: psychometric validity, relevance to theoretical approach, applicability to outcome research in school settings, readability, ease of completion, and self-administering time (Crawford-Seagram, 1997). The instruments selected were the Homework Problem Checklist (HPC) (Anesko et al., 1987), the Behavioral and Emotional Rating Scale (BERS) (Epstein & Sharma, 1998), and the Social Skills Rating System (SSRS) (Gresham & Elliott, 1990).

Homework Problem Checklist (HPC). The HPC was used to assess the participants' homework completion skills. The HPC is a 20-item instrument designed to measure the frequency and intensity of children's homework problems. The 20-item questionnaire is administered to parents for assessing the difficulties their children are having with homework. The HPC uses a Likert scale in which "never," "at times," "often," or "very often" are used. The HPC is easily scored by summing the 20 items, which then produces a score between 0

and 60. The higher the summed score, the greater frequency and intensity of homework problems, as rated by the child's parent (Anesko et al., 1987; Corcoran & Fisher, 2000).

Reliability and validity measures indicate that the HPC has routinely displayed excellent internal consistency levels with an alpha level of .91 and good known-groups validity; significantly discriminating between children rated by their parents as "below" versus "on or above grade level." Most important, the HPC is an excellent measurement that is sensitive to change produced by an intervention (Anesko et al., 1987; Corcoran & Fisher, 2000).

Behavioral and Emotional Rating Scale (BERS) and Social Skills Rating System (SSRS). The BERS and the SSRS were used to assess the classroom behavior and social skills displayed by the treatment participants. The BERS consists of 52 items that rate the participant's interpersonal strengths, family involvement, intrapersonal strengths, school functioning, and affective strengths (Epstein & Sharma, 1998). Routinely, the BERS has demonstrated consistent reliability and validity across multiple raters (Early, 2001).

Internal consistency of the total scale and subscales along with test-retest reliability measurements conducted with school-age children has shown the BERS to be consistently strong and high. The interrater reliability coefficients have ranged from .83 for interpersonal strength to .96 for family involvement, with total scale interrater reliability at .98 (Epstein & Sharma, 1998). The BERS was used and completed by the participants' teachers.

Administered to students participating in the study, the SSRS assesses student cooperation, assertion, responsibility, empathy, and self-control and can be used in conjunction with a treatment intervention to assess behavior in the classroom. The SSRS provides a broad outcome measurement of a student's social behaviors—behaviors that can affect teacher-student relations, peer acceptance, and performance (Gresham & Elliott, 1990). The SSRS consists of 34 items that use a Likert scale in which 0 = "I never do this behavior," 1 = "I sometimes do this behavior," and 2 = "I very often do this behavior."

The SSRS was standardized on a national sample of 4,000 students and youths between ages three and 18. The sample was selected from 18 states and

was stratified by grade and gender, with separate norms for boys and girls and for students who were classified as emotionally impaired and not emotionally impaired. Routinely, the SSRS has shown strong and high reliability and validity. Across all forms and levels, the SSRS median coefficient alpha reliability was .90, and the internal consistency estimates ranged from .83 to .94 (Gresham & Elliott, 1990).

Procedure

To test the treatment effectiveness of SFBT, multiple data assessment periods took place. Assessment sessions using the HPC, BERS, and the SSRS began during the fourth marking period of January 2002 (that is, pretest and session 1 of SFBT) and at the onset of the fifth marking period during mid-March 2002 (that is, posttest and session 8 of SFBT). There was a six-week follow-up assessment at the end of April 2002 using the SSRS instrument with the participants.

Each SFBT group facilitator administered the SSRS during session 1 and session 8 of the study. According to each group facilitator, the SSRS took approximately 20 to 30 minutes to complete. During the six-week follow-up assessment, the two MSW II interns and I co-administered the SSRS in a group format to the participants. The follow-up assessment lasted approximately 25 to 30 minutes.

The HPC, which required the participant's parent's participation and completion, was administered on two occasions. The HPC was mailed to parents at the onset of SFBT treatment beginning mid-January 2002 and at the conclusion of SFBT treatment during mid-March 2002. To ensure consistency, the HPC was mailed to each parent on the day in which their child was assessed using the SSRS. Parents who did not return the HPC within two weeks from the time of mailing received a follow-up phone call requesting completion and return of the measurement. As a result, all HPCs were returned.

The BERS, which required teachers' participation and completion, was also administered on two occasions: at the onset of SFBT treatment beginning mid-January 2002 and at the conclusion of SFBT treatment during mid-March 2002. To ensure consistency the BERS was given to lead teachers representing the participant's grade (that is, either seventh or eighth grade). The BERS was completed by groups of teachers; items were read

aloud by lead teachers and then discussed and agreed on by the teachers relative to the participant receiving treatment. Lead teachers who did not return the measurements within the two-week time frame of the pretest and posttest received a note in their mailbox asking for their return. As a result, all BERS were returned.

RESULTS

Univariate, bivariate, and multivariate analyses were conducted to test the effectiveness of SFBT. Comparisons are presented from time 1 (pretest) to time 2 (posttest), and time 3 (six-week follow-up) using the SSRS. Comparisons are also presented between time 1 and time 2 for teachers using the BERS and parents using the HPC. Differences and changes in the mean scores were considered significant at the $p < .05$ level.

Sample Characteristics

In general, the response to participation was positive. At the onset, 28 students agreed to participate in one of the four SFBT treatment groups. However, two of the 28 participants moved from the school district during week 3 and week 5 of treatment. As a result, only 26 participants received SFBT for eight weeks and were included in the analysis. White participants made up 80 percent ($n = 21$) of the sample, followed by African Americans who made up 20 percent ($n = 5$). Seventy-three percent ($n = 19$) were boys, and 27 percent ($n = 7$) were girls. Fifty percent ($n = 13$) were in the seventh grade, and 50 percent ($n = 13$) were in the eighth grade, with a mean age of 13.19 ($SD = .74$).

Participant SSRS Scores from Time 1 to Time 2 and Time 2 to Time 3

Significant group differences emerged from initial assessment to completion of treatment using the SSRS. A one (group) by three (time periods) repeated measures analysis of variance revealed a significant effect for the within-subjects factor of testing time on the SSRS [$F(1, 25) = 15.36; p < .001$]. The changes in time accounted for 38 percent of the total variation in participant scores (partial $\eta^2 = .38$). Polynomial contrast comparisons of this statistically significant pattern of change over time revealed significant linear [$F(1, 25) = 15.93; p < .001$] and quadratic [$F(1, 25) = 14.71; p < .001$] effects.

Visual inspection of the mean scores indicated that the significant linear effect was due primarily to a large change in SSRS scores between time 1 ($M = 42.34$; $SD = 11.23$) and time 2 ($M = 51.81$; $SD = 12.34$). However, the participants' scores leveled off and did not increase between time 2 and time 3 ($M = 49.73$; $SD = 10.08$), accounting for the significant quadratic effect. In other words, students improved dramatically after the eight weeks of the intervention and maintained these gains at the six-week follow-up but did not show further improvement.

Teacher BERS Scores between Time 1 and Time 2

Significant group differences emerged from initial assessment to the completion of treatment using the BERS. Bivariate analysis of teacher responses on the BERS found that participants receiving SFBT exhibited improvements from the onset of treatment to the conclusion of treatment. Specifically, paired sample t tests indicated that the mean total score at the conclusion of treatment was $M = 75.23$ ($SD = 18.84$), whereas the mean total score at the onset of treatment was $M = 64.88$ ($SD = 21.19$). This finding was statistically significant on the BERS [$t(25) = 3.59$, $p < .01$] immediately following treatment.

Parent HPC Scores between Time 1 and Time 2

Statistically significant differences also emerged from initial assessment to the completion of treatment using the HPC. It should be recalled that the lower the summated score on the HPC, the less problematic behavior the student exhibits in completing his or her homework as perceived by his or her parents. Bivariate analysis of parent responses on the HPC found that participants receiving SFBT exhibited improvements from the onset of treatment to the completion of treatment. Paired sample t tests indicated that the mean total score at posttest was $M = 27.73$ ($SD = 12.06$) whereas the mean total score at the onset of treatment was $M = 31.57$ ($SD = 13.42$). This finding was statistically significant on the HPC [$t(25) = 3.17$, $p < .04$] immediately following treatment.

DISCUSSION

SFBT has demonstrated some success with at-risk and K-12 populations (Dielman & Franklin, 1998;

Franklin et al., 2001; Teall, 2000; Thompson & Littrell, 1998; Watkins & Kurtz, 2001). The results of the present study point to the importance of SFBT in addressing at-risk youths who were identified for school underachievement. More important, there appears to be some evidence for the continued use of SFBT with at-risk populations. In fact, statistically significant change was found along social and behavioral areas with this population.

It was found that group participants enhanced their social skills from pretreatment to posttreatment as measured by the SSRS. Students participating in SFBT improved after treatment and maintained these gains at the six-week follow-up. The findings also suggest that the content covered in each group session cultivated the participants' strengths in maintaining this change. Over the eight weeks of treatment, participants focused on present and future goal attainment instead of the problems associated with their behaviors. Such content may have provided participants with an image of what school could be like when goals are formulated and a vision of the future takes place.

Similarly, it was found that participants improved their overall classroom behavior as measured by the BERS. To the point, teachers perceived behavioral and social gains in the classroom for participants receiving SFBT. Changes on the SSRS and BERS instruments are of particular interest because they suggest a potential link between the participants' recognition of dealing appropriately with teachers and peers in the classroom and the interpersonal strengths developed during SFBT treatment.

Parents also perceived that participants receiving SFBT displayed fewer issues related to homework completion. Thus, parents perceived higher on-task completion of homework at the conclusion of SFBT treatment. The importance of this finding is that the completion of homework has been strongly linked to the students' academic success. This is especially important given the demands placed on school social workers to identify interventions that affect the academic and behavioral success of students (Franklin, 2001). However, these results should be interpreted with caution, as there were several limitations in the study.

Limitations

Although the findings from this study are encouraging, they are far from conclusive. Given the small sample size and the research design, the degree to

which the findings can be generalized is limited. In addition, a comparison group was not included in the analysis. Testing SFBT under experimental or quasi-experimental conditions with a comparison group could aid in assessing SFBT effectiveness.

It is also unclear whether the changes on the SSRS, BERS, and HPC were the result of some other factor. Researchers and practitioners must recognize that participants are aware of the social desirability of answers when using self-reports (Cook & Campbell, 1979). Responses from self-reports, therefore, should encompass other behavioral and academic data to help confirm their findings. Issues such as the time of year SFBT took place, the maturation of participants, and other environmental events may also have influenced treatment outcomes. In addition, the tracking of additional interventions (that is, meetings with school counselors, school psychologists, assistant principals, school building principals; the use of parent-teacher conferences; and treatment provided by outside agencies) should have been monitored to fully assess and evaluate the gains attributable to SFBT. Last, there was no random assignment or sampling within the research design. Parents and students volunteered to participate in the study, thus self-selection biases may be present. Despite these limitations, some implications for school social workers can be drawn.

Implications

Tremendous pressure has been placed on school social workers to enhance the behavioral, social, and academic competence levels of at-risk youths. More important, school social workers have a responsibility to nurture a future with at-risk youths that is filled with aspiration and hope. The results from this study provide support for the continued evaluation and application of SFBT with at-risk youths by school social workers.

The results of this study suggest the effectiveness of SFBT in addressing issues that are important to student success. Students who received SFBT showed improvement on each of the three scales used in the study. Favorable outcomes were found in improvement of social and behavioral areas as measured by the SSRS and BERS. More important, students participating in SFBT displayed gains on each of these instruments despite the severity of their academic performance and attendance patterns during the previous year. Such find-


ings are important given that schools are social systems in which at-risk populations must socially interact and respect boundaries established by peers, teachers, school administrators, and support staff.

Favorable outcomes also were found in home behaviors associated with the completion of homework. These findings are important given the rewards often associated with homework completion. Even more important is that SFBT helped augment attitudes and behaviors regarding homework completion as perceived by parents. Parents reported fewer problems associated with homework completion at the conclusion of SFBT.

This finding is also of interest given the current escalating demands placed on school social workers to identify treatment interventions that affect student success. As a result of these demands, emphasis in many K-12 settings is placed on how well school social workers' interventions affect the bottom line. In fact, many school administrators and principals readily assert the importance of interventions that enhance the academic and behavioral success of at-risk populations. Accordingly, the results from this study not only provide support for the application of SFBT with at-risk junior high school students, but also address issues asserted by school stakeholders.

CONCLUSION

Research over the past two decades suggests the importance of identifying interventions that improve the academic and behavioral success of at-risk students. Researchers and practitioners assert the factors and complexities associated with being at risk and their potential impact on child and adolescent well-being. This study found that SFBT has potential in facilitating and empowering at-risk students in junior high school settings. It also suggests that SFBT may contribute to the empowerment of at-risk students in developing a more optimistic vision of the future.

However, it should be pointed out that SFBT is not a remedy to the issues affecting at-risk youths in K-12 settings. SFBT is by no means meant to replace the preventive measures designed to address the roots of the problem. More important, the ultimate success of addressing this vulnerable population can occur only when broad-scale social, economic, political, and educational reforms take place in K-12 settings. 

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